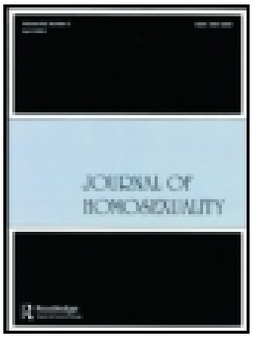

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Healthcare Needs and Care Utilization among Lesbian, Gay, Bisexual and Transgender Populations in New Jersey

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Abstract

The purpose of this study was to explore prevalent health issues, perceived barriers to seeking healthcare, and utilization of healthcare among lesbian, gay, bisexual and transgender (LGBT) populations in New Jersey. A cross-sectional online survey was administered to 438 self-identified LGBT people. Results identified health needs which included management of chronic diseases, preventive care for risky behaviors, mental health issues and issues related to interpersonal violence. Barriers to seeking healthcare included scarceness of health professionals competent in LGBT health, inadequate health insurance coverage and lack of personal finances, and widely dispersed LGBT inclusive practices making transportation difficult. There is a need for better preparation of healthcare professionals who care for LGBT patients, to strengthen social services to improve access and for better integration of medical and social services.

Keywords: LGBT health, healthcare utilization, barriers to care, mental health, LGBT healthcare encounter.

Approximately 9 million people, or 3.5%, of the total U.S. population identify as lesbian, gay, bisexual or transgender (LGBT) (Gates, 2011). Additionally, the percentage of the U.S. population who identified themselves as lesbian women and gay men ranged from 2.2% to 5.6% respectively (Gates, 2014). These enumerations are estimations at best because until recently U.S. federal agencies collected limited data on gender identity or sexual orientation. For example, the 2010 Census data offer information on same sex couples but not on sexual identity. There are limited data on the health needs and healthcare utilization patterns of the LGBT populations (Institute of Medicine, 2011). Although the Centers for Disease Control and

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Prevention (CDC) developed a question module for inclusion in the Behavior Risk Factor Surveillance System (BRFSS) on sexual orientation and gender identity in 2013, only twenty-five states and territories used the module in 2015 (Baker & Hughes, 2016).

The healthcare needs of the LGBT populations are unique (Institute of Medicine, 2011; Meyer, 2013). This population experiences a heavier burden of anxiety from social stressors such as stigma, discrimination and prejudice (Meyer, 2013). The prevalence of mental health issues, suicidal ideation and attempted suicides is higher among LGBT individuals (Figueiredo & Abreu, 2015; Meyer, 2013). The incidence of HIV infection is highest among gay men (Institute of Medicine, 2011). Cardiovascular diseases and obesity have been reported as a special concern among older lesbian women (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). In addition, substance abuse and low rates of screening for HIV, HPV and cancer are also common health related issues reported by these populations (Fredriksen-Goldsen et al., 2013). Many of these issues are rooted in the stress experienced as a sexual and gender minority as well as maladaptive coping resulting from internalization of negative societal attitudes (Meyer, 2013). Given the complexities of LGBT health needs, understanding sexual orientation and gender identity is critical in healthcare settings because healthcare providers care for people when they are most vulnerable and can significantly influence health outcomes (Institute of Medicine, 2011). The Institute of Medicine (IOM), National Institutes of Health (NIH) and Healthy People 2020 have also called for increased demographic and epidemiological research that focuses on social challenges and healthcare inequalities, such as discrimination, stress, and the specific health needs of LGBT populations.

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In New Jersey, approximately 3.7% of the adult population identify as LGBT (Movement Advancement Project, 2015; Williams Institute, 2015). Yet, a review of the State of New Jersey's official website highlighted the scarcity of information and data on LGBT populations in New Jersey (New Jersey Department of Health, 2013). Furthermore, New Jersey is one of the states that have not started to collect sexual orientation or gender identity data (Baker & Hughes, 2016). We undertook this study to address this gap and examined the utilization of healthcare patterns, health needs and barriers to seeking care among the LGBT populations in New Jersey. We also explored the healthcare encounter between LGBT patients and health care providers to inform health professional education.

Method

Design

Using social media, a descriptive, cross-sectional survey design was used to obtain data on the healthcare needs and patterns of healthcare utilization of the LGBT populations in New Jersey. The study was advertised on newjersey.craigslist.org, NJgaylife.com, websites of the Central Jersey Lesbian Alliance, New Jersey Gay Health and locally at the African American Office of Gay Concerns in Newark, New Jersey and Hudson Pride in Jersey City, New Jersey. Respondents were directed to an online survey hosted on Survey Monkey via a link. The survey design was based on other LGBT needs assessment instruments and modified for the purpose of this study (Aitken, Kealey, & Adamson, 2007; Frazer, 2009; Grant et al., 2011; Tulsa Reaches Out Project, 2005; Wesch, 2012). With the collaboration of the Rutgers University LGBT health

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working group members the items from the four identified instruments were reviewed and condensed to fit the scope of the study with a focus on healthcare. The working group (n=20) also pilot tested the survey items. The final version of the survey was administered in English and comprised of fourteen items. The survey included items on demographic information, prevalent health issues, perceived barriers to seeking healthcare, and utilization of healthcare. The Rutgers University Institutional Review Board approved the project.

Sample

Based on previous estimates of LGBT populations in New Jersey (3.7% of the total population) (Movement Advancement Project, 2015; Williams Institute, 2015) we calculated that a convenience sample of 384, with a confidence interval of 95%, would be sufficient to achieve 80% study power (Merril, 2012). A total of 438 self-selected respondents, 18 years of age or older that self-identified as lesbian, gay, bisexual or transgender, participated. We offered a $25 gift card to 100 of the respondents by entering them into a lottery.

Data Analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS) Version 23 for Windows. Descriptive analysis was used to summarize participants' demographic information and other responses to the survey questions. Pearson Chi-square test of independence was utilized to determine whether sexual orientation, gender, age, race, ethnicity,

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relationship status, and residential location varied by utilization of care. All quantitative statistical tests were two-sided. A p value of ≤ 0.05 was considered statistically significant.

Results

Demographics of respondents

One hundred and forty-one (32.2%) Lesbian women comprised the largest group in this study sample. Almost half of the participants (48.4%, n=212) identified themselves as female, which included lesbian, bisexual and transgender women. The largest number of participants were under 25 years of age (26%, n=114), and more than half (56.8%, n=249) of the survey respondents identified as White, non-Hispanic or Latino white. The largest communities of color identified as Black/African American. Most respondents indicated that they were single or not in a committed relationship (46.1% n=202). Geographically, the respondents represented all of New Jersey's 21 counties.

Most participants reported that their friends (52% n=345) and family (41% n=346) were aware of their sexual and gender identity. Only 39% (n=341) were out to all their healthcare providers. However, those who had not disclosed their status cited awkwardness, stigmatization and discrimination as three major reasons for not being 'out'. Of these, 27% (n=117) of respondents felt awkward coming out to their families, 20% (n=89) to their friends, and 19% (n=81) to their healthcare providers. While, 16% (n=71) had not disclosed to their families, 9% (n=40) to friends, and 11% (n=49) to healthcare providers for fear of stigmatization. Thirteen

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percent (n=58) of the respondents had not disclosed to family, 9% (n=41) to friends, and 12% (n=54) to healthcare providers for fear of being discriminated against.

Health Issues by Sexual Orientation

Physical and sexual health: The health concerns, voiced by the participants, are presented in Figure 1. The major health issues included HIV, acute infections, sexually transmitted diseases, gastric problems, and hypertension.

Behavioral Health: Figure 2 shows the major behavioral health needs identified by the respondents. These included mental health needs, prevention of risky behaviors and issues related to interpersonal violence. Mental health was the most commonly identified health concern by all participants (ranging between 72% and 86%), with the transgender respondents (86% n=23) reporting the highest need.

Healthcare Access

Nearly 13% (n=57) of respondents reported that they were uninsured. Transgender people reported lacking health insurance in greater numbers than other respondents in this survey with only 6.7% (n=20) having health insurance. In addition, approximately 80% (n=347) of respondents did not seek care on a regular basis and underutilized health care. When they did seek care, physicians were the usual source of care, followed by nurse practitioners. Also, 12% (n= 40) of participants reported that they consulted community health workers for their HIV testing and follow-up.

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Perceived Barriers to Healthcare Assess

Respondents reported numerous barriers to seeking healthcare which included financial need, lack of cultural competency on the part of the healthcare providers, poor transportation connections to LGBT specific healthcare services, adequate and affordable housing and a lack of mental health services. See Figure 3. A lack of financial resources was cited by 63% (n=276) of the respondents. Half of the respondents (54 % n=238) chose 'strongly agree' or 'agree' with the statement "fear that if medical personnel find out an individual is LGBT they will treat them differently". Half of the transgender sample reported that physicians and other healthcare workers had refused to provide services to them at some point and said that social stigma and fear of community response was also a problem in attempting to access services. Further, 53% (n=233) strongly agreed or agreed that "lack of health professionals who are adequately trained and competent to deliver healthcare to LGBT people" was a barrier. A majority of transgender respondents (71%, n=27) indicated that there was a need for more health professionals who are adequately trained to deliver healthcare that is particular to transgender needs. In addition, nearly half, 47% (n=208), of the respondents identified lack of psychologists, social workers and mental health counselors with knowledge of LGBT mental health issues as a perceived barrier.

Race also shaped perceptions of barriers to seeking healthcare. Asian participants experienced more barriers to healthcare access related to refusal of care and stigma. Approximately 41% (n=87) of White respondents and 47% (n=30) of Black/African American respondents strongly agreed or agreed with the statement 'Doctors and other healthcare workers who refuse to provide services to LGBT people' was a problem in accessing healthcare for them,

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but 65% (n=11) of Asian respondents said this was a problem. A total of 90% (n=17) of Asian respondents also reported that social stigma or fear of community was a problem in attempting to access services compared to 59% (n=135) of White and 71% (n=51) of Black/African American respondents.

Healthcare Utilization Patterns

Participants utilized the following health care services the most. 1) mental health, 2) management of chronic diseases, 3) primary care, 4) addictive behaviors, 5) prevention of violence related behavior, 6) prevention of risky behaviors and 7) reproductive needs.

The results showed that 54% (n=236) of the participants utilized mental health care services; 47% (n=206) reported using healthcare to manage chronic disease; only 27.2% (n=119) reported using primary care regularly. In addition, 17.8% (n=78) of the participants reported that they utilized care for addictive behaviors. Another 17.8% (n=78) reported that they had utilized healthcare for the violence related incidents. A third, 32% (n=140), reported that they utilized healthcare services for information on the prevention of risk behaviors. Utilization of reproductive services was low with 8.9% (n= 39) reporting seeking such care. See Table 2.

In the utilization patterns, management of chronic diseases ($p<.000$), risk behaviors ($p<.000$) and reproductive needs ($p=.001$) were significantly different by participants' sexual orientation. Gay men were most likely to utilize healthcare for chronic diseases and prevention of risky behaviors. Bisexual participants were most likely to utilize healthcare for reproductive needs. Similarly, utilization of healthcare was significantly different by participants' gender for

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management of chronic diseases, risky behaviors and reproductive needs (p=.001, p<.000 and p=.006, respectively). In addition, utilization of healthcare for management of chronic disease, for violence related issues and prevention of risky behaviors differed significantly by participants' race (p=.001, p=.038 and p=.014, respectively).

Discussion

Mental health was of critical concern to the LGBT populations in New Jersey. According to previously published research LGBT populations were 1.5 times more likely to suffer from depression and general anxiety disorders (Bostwick, Boyd, Hughes, & McCabe, 2010), and were at a greater risk for suicidal ideation (Figueiredo & Abreu, 2015; Wang, Häusermann, Wydler, Mohler-Kuo, & Weiss, 2012). We found that lesbian and bisexual participants reported the highest utilization of mental healthcare and expressed the greatest need for mental health support. We also found that interpersonal violence, a predictor of depression, was common among our sample with 16 % of gay men, 13 % of transgender respondents, 11 % of bisexual participants, and 10% of lesbian women reporting such incidents. Although our study found that the utilization of mental health services was high, indicating that the participants were accessing care, many indicated that providers should possess current knowledge of LGBT mental health issues; there should be greater access to psychologists and support groups. Another area of concern was the large population of respondents who did not disclose their sexual identity for fear of discrimination at the hands of the providers of care. This adds to the burden of stress and compounds the mental health issues of these populations, but also shows that providers are not sensitive to their patients' needs. Although healthcare professional education has embraced

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cultural sensitivity, cultural humility and cultural competence, LGBT friendly and inclusive providers are in the minority (Sabin, Riskind & Nosek, 2015).

Gay men, transgender people and bisexual individuals indicated the greatest need for preventive care for risky behaviors including prevention of STDs. Reviewed literature indicated that this segment of the population was more likely to engage in risky sexual behaviors (Holloway, Pulsipher, Gibbs, Barman-Adhikari, & Rice, 2015) and had the highest incidence of sexually transmitted diseases such as gonorrhea and syphilis (Ling et al., 2015). This is an area where healthcare providers can play an important role in educating their LGBT patients about risky sexual practices. Therefore it is important that healthcare provider education include evidence based information on the specific health needs of LGBT populations and current strategies for prevention. In addition, information on preventive strategies targeting risky sexual behaviors can be provided to the LGBT populations directly via social media campaigns, published materials and information on locally available care can be delivered via the Internet or web applications since this population consumes more information online (Holloway et al., 2015).

We found that transportation to LGBT care centers was an issue and many respondents cited financial concerns. LGBT populations in New Jersey do not have many options for specialized LGBT care and many sought care out of state (Stainton, 2016). This means patients have to experience undue travel and financial burden for routine healthcare in New Jersey. Here, State Health and Transportation departments can coordinate efforts in addressing this issue. Transit card systems usually accepted by buses and trains can be expanded to include other

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modes of transportation such as taxis. This may also address the financial barrier identified by our respondents.

Participants over forty years of age reported the greatest need for chronic disease management. Chronic diseases included hypertension, diabetes, cardiovascular diseases, tuberculosis, HIV, cancer and hepatitis. We found that gay men faced significant chronic health challenges with approximately half of our sample reporting living with HIV while some of them needed care for hypertension and other cardiovascular diseases. These conditions require long term or life-long care including follow up care. This is where primary care providers can help. However, participants reported that providers need better preparation around LGBT health and improved sensitivity to their health issues.

It is important to underscore that although most respondents reported physicians as their providers many sought preventive care, particularly for HIV testing and follow up, advice from community health workers. This may be because community health workers are part of the communities they serve and LGBT people may feel more comfortable talking to them. This also reflects on the discriminatory experiences with other healthcare providers (Rounds, McGrath, & Walsh, 2013).

Another important barrier to seeking care was a lack of personal financial resources. This might be connected to their seeking care out of state (Stainton, 2016), insurance regulations pertaining to re-imbursement and the specialized care they may need. Since many do not seek care on a routine basis, they may seek emergent care for conditions that could have been addressed by regular primary care, which ends up being more expensive.

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Based on the findings of this study, we also found that some key population subgroups faced greater barriers. These included transgender and Asian respondents. It should be pointed out that Asians are a diverse group and ethnic origin may provide some insight into culturally ingrained patterns of behavior. For example, among East Asians, Koreans were more secretive and least likely to disclose if they were lesbian, gay or bisexual (Kimmel & Yi, 2004).

There are a number of limitations to this study. The use of a small sample of convenience in one state limits generalizability. Our reliance on social media and online completion of the survey may have missed people without access to the internet, those with limited access or those who use the internet infrequently, particularly those who are 65 years or older. Future research should consider other methods of data collection to access LGBT people who may have been missed. This was an exploratory study and the data were mostly descriptive. Descriptive studies are useful for understanding the needs of communities, and may serve as the first step towards development of new and reinforcing existing programs.

Conclusions

Our findings begin to provide a greater understanding of the needs and resources necessary for adequate healthcare of the LGBT population in New Jersey. Despite tremendous progress New Jersey statewide health surveys and other data collection need to consistently include reliable, valid questions about LGBT identity. For example, the Behavioral Risk Factor Surveillance System has developed a question module on sexual orientation and gender identity which New Jersey can implement. In addition the state can play a crucial role in the health

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insurance, housing and transportation issues identified. This can be addressed by better integration of health and social services.

New Jersey is home to more than 150 accredited nursing programs, four medical schools, numerous allied health professional training programs and prepares thousands of healthcare professionals every year. This provides New Jersey with the opportunity to train a healthcare workforce which is knowledgeable about LGBT health issues and sensitive to their unique needs. To this end, healthcare professional educational programs should reassess the content on LGBT health in their curricula and LGBT competency training for healthcare providers. LGBT competency assessment and education must also attend to the varied ways in which race, ethnicity, and economic status intersect with sexual and gender identity in shaping health care experiences. A better understanding of these social determinants of health would strengthen education programs and may help alleviate many of the barriers to care that were reported in this study.

Finally, LGBT adults and youth also need to be engaged in primary care and have regular check-ups. Preventive primary care and seeking care on a regular basis allow health issues to be detected early and improves the chances of living a longer and healthier life. Indeed a more culturally aware healthcare workforce would encourage engagement and improve patient provider interactions and health outcomes. In addition, mental health services and support groups for LGBT people were found to be lacking in this study. Lack of these services was considered to be a pressing need for many respondents, and particularly for transgender people and Asian people.

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We have shared our findings with the New Jersey Office of Minority Health and presented them at national public health and nursing meetings to bring attention to the needs of the LGBT populations in New Jersey.

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Table 1Demographics of Respondents

	N	%
Sexual Orientation		
Lesbian	141	32.2
Gay	114	26.0
Bisexual	126	28.8
Heterosexual transgender	32	7.3
Others (e.g. queer, asexual, fluid, pansexual et.al)	25	5.7
Gender		
Female	212	48.4

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Male	145	33.1
Male to female transgender	13	3.0
Female to male transgender	14	3.2
Age		
Under 25	114	26.0
25-34	109	24.9
35-49	92	21.0
50-65	67	15.3
Over 65	9	2.1
Race		

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Black or African American	75	17.1
White	249	56.8
Asian	20	4.6
Two or more race	18	4.1
Ethnicity		
Non-Hispanic or Latino	308	70.3
Hispanic or Latino	55	12.6
Relationship Status		
Single or not in a committed relationship	202	46.1
Married or in a civil union	64	14.6

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Live with a partner	103	23.5
Widowed	9	2.1
Residential Location (Zip codes)		
Large urban area	108	24.7
Midsize city	53	12.1
Small city or town	93	21.2
Suburban	101	23.1
Rural area	26	5.9

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Table 2 Utilization of Care

	Mental health %	p	Management of chronic disease %	p	Primary care %	p	Addictive behavior %	p	Violence related behavior %	p	Prevention of risky behavior %	p	Reproductive needs %	p
Sexual orientation		.908		.000**		.210		.135		.201		.000**		.001**
Lesbian	35.6		28.2		33.6		26.9		28.2		20.7		38.5	
Gay	27.5		33.0		27.7		30.8		29.5		35.0		7.7	

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Transgender	7.2	6.8	5.0	9.0	7.7	9.3	2.6
Bisexual	29.7	32.0	33.6	33.3	34.6	35.0	51.3
Gender	.218	.000**	.648	.097	.371	.000**	.006**
Male	35.8	48.3	35.3	44.7	41.6	46.4	15.8
Female	55.9	44.8	59.5	46.1	53.2	44.9	84.2
	8.3	6.9	5.1	9.2	5.2	8.7	0.0

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Transgender							
Age	.209	.003**	.070	.416	.021*	.188	.113
<25	28.4	21.8	23.5	24.4	34.6	30.0	33.3
25-34	30.1	26.7	23.5	21.8	34.6	31.4	30.8
35-49	23.3	29.1	34.5	33.3	24.4	24.3	33.3
50-65	16.9	19.9	16.8	17.9	6.4	12.1	2.6
>65	0.8	2.4	1.7	2.6	0.0	2.1	0.0

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Race	.327	.003**	.400	.566	.038**	.014*	.808
White	63.6	63.1	68.1	65.4	48.7	57.9	53.8
Black/ African American	20.8	24.8	17.6	21.8	30.8	26.4	28.2
Asian	6.4	3.4	2.5	3.8	5.1	3.6	5.1
Two or more races	3.0	3.9	5.0	2.6	6.4	3.6	5.1

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Ethnicity		.36 3	.13 6	.52 0	.11 3	.15 1	.05 4	.37 3
Hispanic or Latino	13.6	12.6		10.1	16.7	19.2	15.0	20.5
Non-Hispanic or Latino	80.9	81.6		83.2	75.6	70.5	77.9	76.9
Relationship Status		.27 8	.05 8	.43 8	.51 9	.57 7	.27 5	.11 4
	15.7	18.4		19.3	16.7	14.1	15.0	30.8

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Married/Civil-Unioned							
Partnered	27.5	24.8	22.7	21.8	24.4	25.0	23.1
Single	53.4	52.9	52.9	57.7	60.3	57.1	46.2
Divorced/Widowed	2.5	3.4	3.4	3.8	1.3	2.9	0.0
Residential Location	.02	.22	.63	.22	.01	.06	.58

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on	6*	8	9	1	6*	3	2
Large urban area	31.9	29.1	23.1	31.2	41.0	34.5	38.5
Midsize city	13.2	13.6	14.5	19.5	16.7	12.9	12.8
Small city or town	21.3	29.1	28.2	26.0	21.8	28.1	23.1
Suburban area	25.5	22.8	27.4	18.2	15.4	18.7	23.1
Rural area	8.1	5.3	6.8	5.2	5.1	5.8	2.6

Note: * p<.05; ** p<.01

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Figure 1. Most common health issues reported by respondents

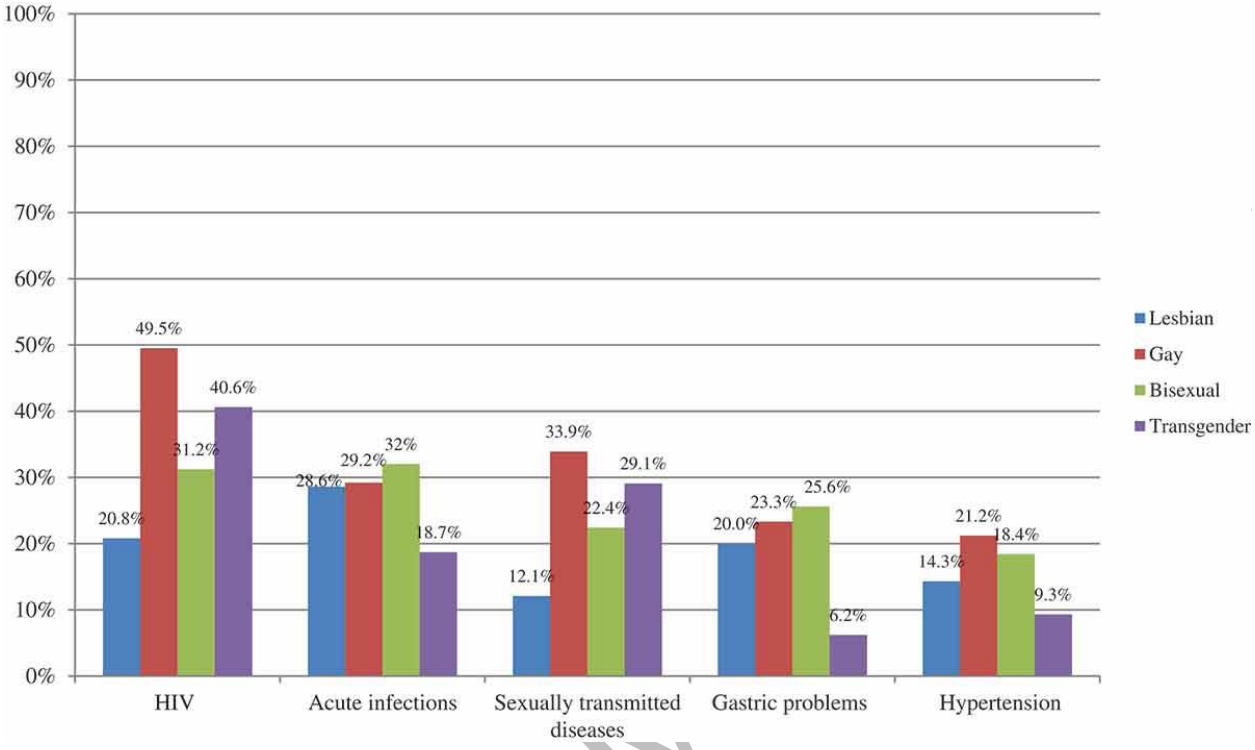

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Figure 2. Most common behavioral health issues reported by respondents

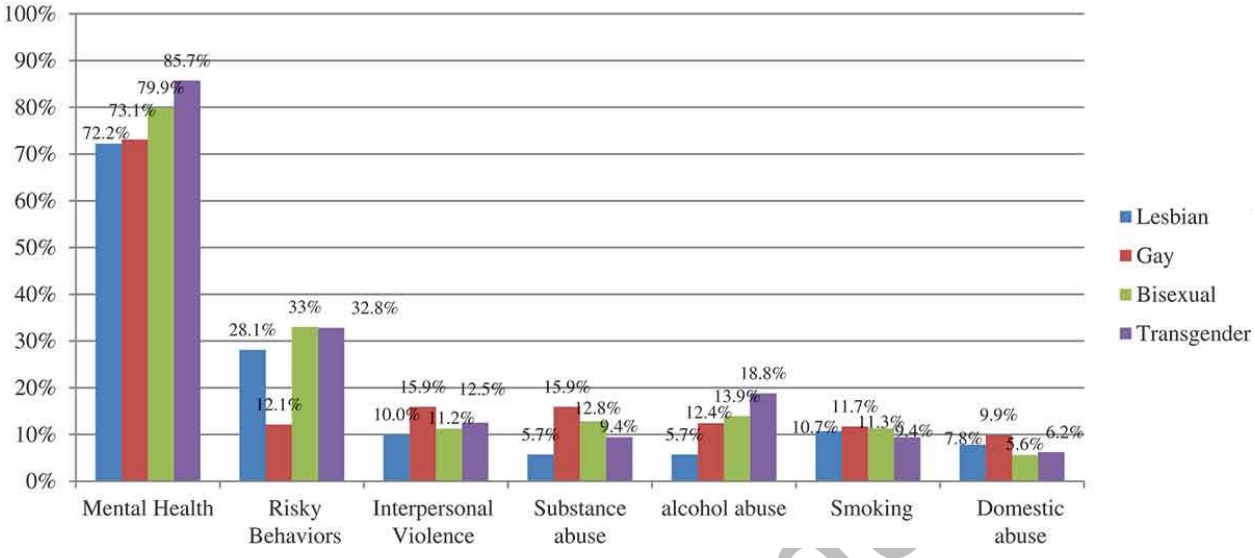

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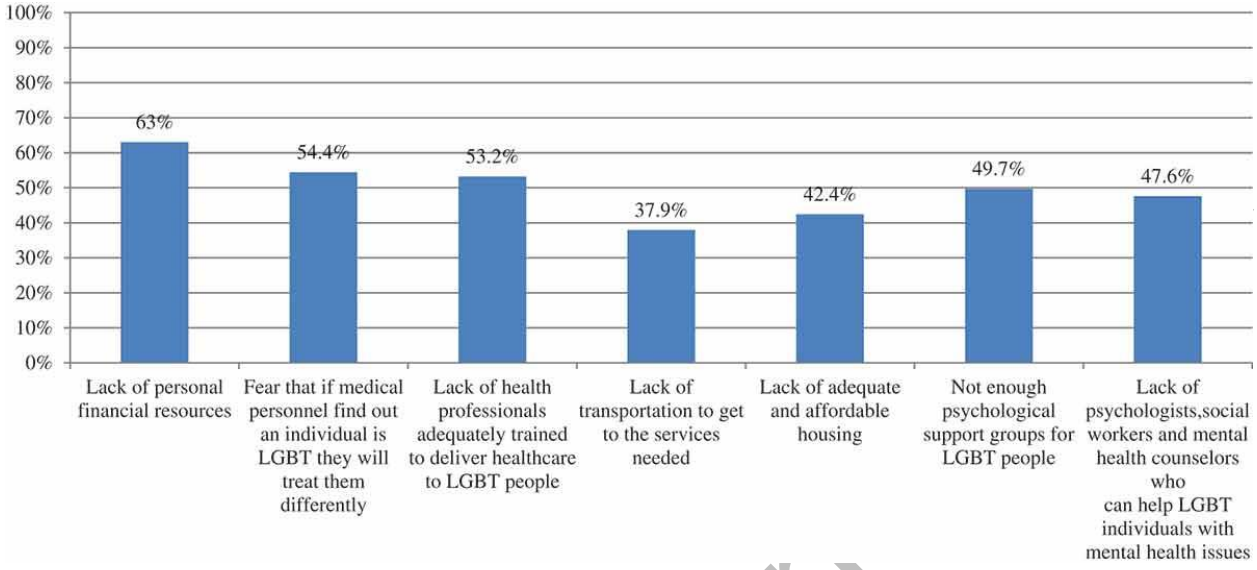
Figure 3. Major perceived barriers to health care assess



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